CDC *Vital Signs* HIV/AIDS Webinar

Lessons Learned and Success Stories

Q&A Transcript

December 6, 2010
2:00pm – 3:30pm EST

Coordinator: At this time we have no one in queue but I'll remind everyone that to ask a question you press star 1 and record your name when prompted. You'll then be announced into conference to ask your question.

If you queue up and then decide to withdraw your question press star 2. One moment please while we wait for questions.

Dr. Judy Monroe: Operator we have some in the queue here already because we've been receiving questions. So...

Coordinator: Okay, we have three that have come up in the audio site, which would you prefer to take first?

Dr. Judy Monroe: Well let's go ahead - well let me ask this first one. This question is what are some effective ways to market HIV testing to the 18 to 24 year olds? So for any of our speakers. Heather do you have some experience with that, effective ways to market HIV testing to the 18 to 24 year olds?

Heather Hauck: I'm chuckling because I think we all struggle with developing culturally linguistically and age appropriate prevention messaging and I think we have some examples of successful general awareness campaigns and testing encouragement campaigns you know across a number of different communities.

But I think it really does take some intensive effort to be able to develop those and quite honestly some rather intensive engagement of the community that you're trying to target.

So for example in Baltimore City there was a group about two years ago that we work with who focus on the team population and they actually worked with the teams to develop a campaign that the tag line is Spread the Word, not the Disease. AIDS is no joke.

And they did t-shirts and some PSAs and some radio spots and the demographic you know that they were targeting with the kids really gravitated towards that.

And I don't have any statistics on whether or not our testing among that age range increased but it certainly was a well received and disseminated campaign.

Dr. Judy Monroe: Thank you very much. Boy I like that tag line that they came up with on that. So operator I want to thank (Shane Ryan) for that first question. And Operator want to go to one of the calls?

Coordinator: Thank you, Michelle Roland you may ask your question.

Michelle Roland: Hi, I'm the AIDS director from California and I have an observation and question about state health department personnel capacity that I'd like to direct to Ann and Heather.

I'm not sure what your staffing structure looked like prior to 2006. In California we have had very few medical professionals in our Office of AIDS health department staff.

And so we've had a fair number of challenges just increasing our own capacity to be able to increase testing in medical centers in our state.

So I'm wondering if you could speak to health department staffing, what sort of people are the right kinds of people to have on our staff? How do you take the people who are really expert on what we've done for years and years which is community based HIV testing and develop their capacity to provide technical assistance in this sort of systems type scale up of HIV testing and medical settings?

Dr. Judy Monroe: Ann do you want to start?

Heather Hauck: Hello, Ann are you going to answer?

Ann Robbins: I'm sorry, I had mute on. We did actually start out Michelle by asking those very questions about what kind of staff did we need to work on this.

And pulled some staff away from focused work on risk based counseling and monitoring and evaluation of those systems.

And at first the folks that we pulled away we based it more on their personal qualities in terms of follow up, eagerness to learn. But as we've gone on we've understood and we added two additional positions that we understood that we needed to recruit folks that were used to working with health systems and do detailing around other kinds of promotions that were basic health promotions.

So we had some new staff that had focused in the past on doing promotions and detailing to hospitals and community health centers that were associated with chronic disease.

And they seemed to be an excellent fit. They know how to speak with physicians and administrators, they know how to sort of embed the HIV transmission, infection, detection referral issues into language and approaches that administrators, clinic and systems administrators are more familiar and comfortable with.

And it has to do with talking about things that our staff had not been traditionally used to speaking about like systems cost and costs averted and looking at the way that staff were detailed within a facility.

So working with people who have experience in working with health systems on a more traditional level have been really helpful.

Heather Hauck: And Michelle I'll just add that we actually did not add any new staff when we received the ETI resources. A number of our ETR program staff who are really excellent staff had already been working with a few healthcare systems including Johns Hopkins University emergency department even prior to the ETI.

So they had a foundation working with health systems and I would say that we chose instead to leverage our AETC resources as well as some champions here in Maryland including Dr. Bartlett and Dr. (Redfield) from Hopkins and IHV University of Maryland respectively as well as some other folks who work in the healthcare systems to add that additional level of technical assistance if we needed it.

Michelle Roland: Thank you.

Coordinator: Our next question is from Fran Phillips, your line is open.

Fran Phillips: Thank you. I'm not sure who to direct this question to. I am so pleased that Heather had a chance to talk about some of the work that we've done here in Maryland and the real progress that we've made.

But looking ahead the issue of how to integrate routine testing in a sustainable way in primary care for all adolescents and adults is really a challenge as has been mentioned by a number of speakers.

So my question is, is it time for the US preventative services task force to take another look at the recommendation for screening, for regular screening, not just for adults and adolescents at increased risk and for those individuals the grade from the task force is an A.

But currently the task force only says there's insufficient evidence to recommend for or against routine screening for persons without identified risk factors, therefore giving it a grade of C.

And as we know how important those grades are with respect to what we can look forward to in the plans, in the health plans as a result of the ACA. So I put that idea and perhaps the question out for anyone that might care to respond.

Thanks so much and thanks for a wonderful Webinar, this is just a great start.

Ann Robbins: This is Ann, the answer is yes to your question.

Fran Phillips: The answer is yes?

Ann Robbins: The answer is yes, it is absolutely essential, I'm going to see if the CDC wants to say anything else.

Dr. Jonathan Mermin: Sure yes, we have been told by the task force that they will be reexamining the question of the effectiveness of routinely offering HIV testing. It has been an important issue for reimbursement and also for the ability to increase the number of people with HIV who know their status.

One of the important issues is that the task force does provide a category A recommendation for people at higher risk which include people from populations where the prevalence of HIV is 1% or greater.

And so if there are many populations for which we would want routine HIV testing to be offered that meet those criteria.

So to some extent it's interpretation of the guidelines and their application in the healthcare setting and the next stage would be hoping that there's enough data to convince the objective external panel that does review this information that in fact opt out HIV testing is effective.

Fran Phillips: Thank you.

Ann Robbins: Can I add sort of a question, a follow up question of my own? I think there's also a matter of looking at the recommendations and seeing how the question and the issue of subsequent testing can be handled with a little bit more guidance and focus than it's currently handled right now.

It's an excellent guidance for getting a testing program started and getting that first in a lifetime test or - but as we look down the line I believe it's a little too under defined in terms of giving guidance on when HIV testing gets you know integrated into primary care, how that should be handled.

So part of your answer Jono handles that but I do want to say from the field we would welcome more thought on that particular issue.

Dr. Jonathan Mermin: I really appreciate the comment. It has been coming up fairly frequently over the past few years that not only are we interested in developing more precise guidance about who would need an HIV test, more than once in their lifetime.

How can we help practitioners and the American public understand when they would need another test and then also people at higher risk who we recommend get tested more than even - or once a year or greater, what does it mean to define oneself in the situation of needing it even more than once a year?

And who would meet those criteria so there's two places where more precise guidance from CDC could potentially be useful and we anticipate examining that through our normal kind of recommendation consultation and review activities so that we can provide more helpful information to health departments and the public.

Coordinator: Are you ready for the next question?

Dr. Judy Monroe: Yes, let's take another question from the phones and then I have a question that's come in on the Web.

Coordinator: (Siga Jang) you may ask your question.

(Siga Jang): Yes, I also want to join my colleagues in thanking everybody, all of the presenters for a wonderful presentation. I believe really, really informative. My name is (Siga Jang) and I'm the AIDS director for the commonwealth of Kentucky.

I have a couple of questions for my colleagues Heather and Ann. Number one I wanted to know both of you kind of talked about some of the natural and non-traditional partners that you worked with in creating champions around routine testing, etcetera.

I do want to know if any of you in particular work with your original education and training centers and if so in what capacity and what types of activities did you do in collaboration with them?

That's one question, the other question I do have is I believe it might have been Heather who talked about some of the information that they sent out to a number of healthcare professionals and how they engaged them.

I wanted to get a little bit more nuance around was there a particular healthcare provider that were targeted or did you just target healthcare providers period?

Or was there more strategy behind that regarding maybe healthcare providers of a particular profession such as infectious disease doctors or originally based depending on their disease prevalence of the providers within a set in region?

And then my last and final question is around did any of you within your jurisdictions have a facility such as an ER where they incorporated routine

testing but maybe after a period of time, say a year of testing their positivity rates were below or very low than what they expected in which they decided to then halt routine testing and if so what was the procedure that they followed in doing so?

Thank you very much again for a wonderful Webinar.

Heather Hauck: I can start by answering the AETC and how did we target question. We did because they're the same answer for Maryland, we did work with our AETC to put together a number of different materials, a toolkit. And they facilitated us being part of - I can think of at least five or six conferences or workshop opportunities to present to both community and providers around the CDC recommendations and changes in Maryland's law.

We worked with - in terms of the provider mailing that we did we worked with our medical society. That got mailed to all providers, we did not target by specialty or practice type.

We mailed that to everybody and then when we worked with the AETC to do workshops, create workshops, not attend conferences or workshops that already existed, but to create workshops we went to three regions of the state to do workshops or dinners that were held for providers.

And then we also worked with our Association for Community Health Centers to convene a Webinar for the community health centers. So again we didn't necessarily target provider specialty practices, we really tried to reach providers across the board.

I think as we go forward and do another round of provider education we might start to work more intensively with larger practices and community health

centers to make sure that we have a foundation there before we move on to sort of the providers at large.

Dr. Judy Monroe: So this is Judy Monroe, we're kind of coming to the end here so I just really want to thank everyone and this being our first Vital Signs Webinar and I think it has gone very well, many of you commented on that.

But one of the things I want you all to think about is thinking about Vital Signs how you might use Vital Signs to push forward your own initiatives and how you can localize the information from Vital Signs and use it to get media attention around the various topics.

And one question we have is how many of you are going to you know take this on and start using the Vital Signs in this way, I know we're limited on time but if there's anyone on the call that would like to let us know how you might use Vital Signs to get more media attention to take these on, does anyone have a comment on that before we close?

Coordinator: We do have one questioner left in the queue.

Judy Monroe: Is that a new question?

Coordinator: No, they've been waiting.

Dr. Judy Monroe: Oh that's right, they have to call in to be able to answer me. Okay, that's right. Okay well anyway those are the questions I'd like folks thinking about.

Operator how are we on time, do we have time for the last question?

Coordinator: You may go ahead as long as you like. Fernando Guerra your line is open.

Fernando Guerra: Okay, this is Fernando Guerra in San Antonio. Great discussion and presentation, I think it's a good start.

And I wanted to ask a question that has probably three parts in it. Has to do with what is the status of testing of active duty military personnel, the status of screening around the country in terms of blood donors and the blood donor pool.

And then also you know there's another group that you know some health departments have to be concerned about and that is those that present to be cleared for citizenship status, that certainly need to have you know an array of tests.

But all of these you know at one time or another will have had some HIV testing but we rarely see information about those particular groups. Is there some available?

Dr. Judy Monroe: Who would like to answer this question? Dr. Mermin?

Woman: I think Dr. Mermin had to leave the call.

Judy Monroe: Heather or Ann?

Ann Robbins: I think it would be more appropriate for Dr. Mermin to respond. I'm not sure that I would know the status from a state health department, from...

Dr. Judy Monroe: We'll get the question to Dr. Mermin and again let's go ahead and honor everyone's time and close out the Webinar today. But I want to really thank

all of our speakers and for all of you that asked questions and please go on line and give us feedback.

There are a few questions that we'd like for you to answer as I discussed before and remember that the slides from today are available also on the OSTLTS Website.

So just thanks to everybody and have a great day.